**MENTAL HEALTH OVERSIGHT ADVISORY COUNCIL**
**July 17 – 18, 2008**

**Minutes**

Members Present: Jim FitzGerald, (Chair), Karen Ward, (Vice Chair), Sara Casey, Joan Daly, Joyce DeCunzo, Leslie Edgcomb, Keith Foster, Gary Hamel, Suzanne Hopkins, Bill Hodges, Andy Hunthausen, Trent Lear, Dorothy McCartney, Michelle Miller, Gary Popiel, Jo Shipman, Lenore Stiffarm, and Patrick Wayne.

Absent: Mary Dalton

Staff Present: Dennis Cox , Marlene Disburg, Mary Jane Fox, Ellen Gartner, Antonia Klein, Dan Ladd, Lisa Miller, Terri O'Herron, Amy Schubert, Deborah Rumberger, and Libbi Pritchard-Sleath

Guests: Natalee Charlton, Gene Durand, Eve Franklin, Kandis Franklin, Lynn Jennings, Sue O'Connell, Tom Peluso, Marty Onishuk, John Schroeck, and Lily Sobolik.

Welcome/Outgoing Members/Minutes

Tom Peluso and Marty Onishuk were recognized for their service to MHOAC. Minutes from the May meeting were reviewed and approved. HOPKINS/Daly

**Proposed MHOAC Improvement Initiatives for Discussion – Jim FitzGerald**

1. Establish clear Council purposes and identify necessary data sets that we need to collect to support such work.
2. Identify what data is being collected now and for what reasons.
3. Achieve Child/Adult balance in membership and attendance.
4. Develop customized report formats for each division/bureau administrator *driven* by what Council wants/needs to know from each, in writing.
5. Improve representation and participation that is meaningful for Native Americans.
6. Identify and establish areas of council focus, i.e. suicide, elderly, child/adult transitions.
7. Establish diverse reports that are pertinent and expand on the Councils ability to grapple with a particular issue of importance.
8. Accurate Block Grant Report on mental health system status and progress across the state.
9. Clear outline of Council reporting deliverables and dates. What are we accountable for and to whom?
10. Legislative monitoring – How do we accomplish this as a Council and toward what end?

11. Legislative reporting – what are our responsibilities to summarize and report on the status of the mental health system?
12. What are the limitations of the Council in fulfilling our statutory role?
13. Build Alliances with whom?
14. Establish Council calendar of activities, reports, etc. and proactively schedule.

Discussion Points

- Purpose for discussion on Improvement Initiatives:
  1. Ensure Council time together is productive
  2. Ensure Council understands more than surface issues.
  3. Impact system for those we serve.
  4. Ensure local and regional entities are aware of Council outcomes.
  5. Ensure Council has the tools it needs to stay focused on agreed upon strategies and State Plan

- Council has ability to create influence; establish a larger stakeholder base for youth and adults.
- Council can work within a public process and still make changes.

**Commitment Law** – Paulette Kohman, DPHHS
Anita Roessmann, Disability Rights Montana

Discussion Points

- Commitment law is not linear
- Rates of commitment to Montana State Hospital over the past five years are a problem.
- Medical or psychiatric care for those without Medicaid
- Anita Roessmann reported that the Law and Justice Interim Committee, which has been studying county pre-commitment costs, jail and prison diversion options for people with mental illness, and unmet needs in the juvenile justice system, has directed its staff to draft a bill that would create options for people who are "respondents" in civil commitment proceedings.
- Under current commitment law, a person can be detained under emergency circumstances, which is when a police officer believes that the person has a mental illness and appears to need treatment. The officer can detain the person for 24 hours, during which time a mental health professional has to evaluate the person. (The person detained for evaluation cannot be held in a jail but has to be in a treatment facility.)
- If the mental health professional agrees the person meets commitment criteria, he or she must ask a county attorney to begin commitment proceedings. If the county attorney agrees, then the judge must be asked to review and approve the petition and, if requested, an order requiring continued detention of the respondent pending the commitment hearing.
- The Judge's approval of the petition and authorization of continued detention is the official beginning of the civil commitment process. It is the point at which the LJIC's

diversion bill would allow the treating professional to recommend the respondent for "diversion for commitment."

- If the Department of Public Health and Human Services agreed, then the respondent would be given the opportunity to agree, in writing, to remain in treatment for up to fourteen days. During that period, the respondent could not leave treatment unless discharged; and both the provider and the respondent would have the right to ask the court to resume the commitment proceeding at any time, because the petition would still be pending.
- At the end of the diversion period (or before, depending on the medical judgment of the treating professional), the patient would be discharged and the commitment petition dismissed.
- Anita explained that the principal problem with diversion, which has been a successful option in Oregon for many years, is funding. Currently, the counties pay for all the costs of caring for the respondent from the time the judge approves the petition until the judge signs the commitment order (or dismisses the case). The state only has to pays for the cost of care of individuals who are civilly committed. Diversion would fall into a funding no-man's land.

**Health Provider Shortage Area (HPSA) Designations – Jon Schroeck**

1. **Health Professional Shortage Area's** (HPSA's) and **Medically Underserved Area's (MUA's)?**

- Federal Designations that determine the underserved area's of the United States. Area's that receive shortage designations can qualify for over 34 Federal Programs including:
    1. National Health Service Corp provider placements
    2. Medicare Incentive Payments
    3. J-1 (Foreign Medical Graduate) Placements
    4. Community Health Center site approval
    5. Federally Qualified Health Center (FQHC) status
    6. Rural Health Clinic certification
- Two main Types Designations HPSA's (PC, Dental, MH) and MUA's. Criteria are established in the Code of Federal Regulations (CFR) Chapter 1, Pt 5 http://bhpr.hrsa.gov/shortage/hpsaguidement.htm
- Designations are developed by the communities in partnership with the Primary Care Office (PCO) in each state.
- Designations are submitted to the Federal Bureau of Health Professions within HRSA for review and approval.
- Designations have prescribed public and review comment periods. Total process usually takes approximately 4-6 months.
- Designations require updating every 4 years.

**2. Once a designation is completed**

- Federal Government assigns a score, which indicates the degree or level of shortage. If score is high enough, communities can qualify to participate in NHSC provider placement programs, including:

1. Loan Repayment
2. Scholars
3. Ready Responders

- The Level of score needed to qualify changes year to year based upon funding and the number of applications submitted to the federal government.

**3. Designation Scoring Criteria for Mental Health include:** Mental Health Provider Ratio's – (In order to receive a designation)

- 30,000 : 1 Psychiatrist to Population Ratio, Or 9,000 : 1 ratio of combined Core MH Providers (CMHP), including Psychiatrists, Clinical Psychologists, Clinical Social Workers, Psychiatric Nurse Specialists, Marriage and Family Therapist to Population. or 6,000:1 CMHP and $\geq$ 20,000:1 psychiatrists
- Designation methodology requires that "rational areas for the delivery of mental health services" be identified.
- Travel Distance
- HIGH NEEDS POINTS – The designation has a Rational Service Area plus one of the following:
    - 20% or more of the population is @ 100% of poverty level, or
    - The youth ratio (# of persons @18 to the # of adults ages 18-64 is greater than .6, or The elderly ratio (# of persons $\geq$ 65) to the # of adults ages 18-64 is greater than .25, or Alcohol or substance abuse prevalence data showing the area to be in the worst quartile of the nation, state, or region.

- Additional information attached to minutes.

**Addictive and Mental Disorders Division Report – Joyce DeCunzo – See Attached Report**

**Block Grant Goals and Objectives – Trent Lear**

The Council reviewed and approved, with changes, the Goals and Indicators for the Adult and Children's Section of the 2009 Mental Health Community Block Grant. Motion to approve Block Grant: DALY/Shipman

**DMA Health Strategies – Mental Health Services Study – Richard H. Dougherty – see attached documents**